

September 9, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1644-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___' IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This ___ reviewer has been certified for at least level I of the TWCC ADL requirements. This physician is board certified in neurosurgery. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 40 year-old male who sustained a work related injury _____. The patient reported that while at work he bent down to pick up some pipe and felt pain in his back. The patient underwent X-Rays of the lumbar spine on _____ and an MRI of the lumbar spine on 7/16/02 that showed disc protrusions at the L4-L5 and L5-S1 levels. The patient has also been diagnosed with mechanical back and has been treated with anti-inflammatories, physical therapy and strengthening exercises.

Requested Services

L3-S1 discogram with post CT scan.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 40 year-old male who sustained a work related injury on -----. The ___ physician reviewer also noted that the patient underwent an MRI on 7/16/02 that showed disc protrusions at the L4-L5 and L5-S1 levels. The ___ physician reviewer further noted that the diagnoses for this patient have included mechanical back and has been treated with anti-inflammatories, physical therapy and strengthening exercises. The

____ physician reviewer indicated that the patient has been referred for a L3-S1 discogram with CT scan to follow. The ____ physician reviewer indicated that the proposed rationale for the discography is to determine percentage of back pain that is discogenic in etiology. However, the ____ physician reviewer explained that performance of facet denervation resulted in complete relief of the patient's back pain. The ____ physician reviewer also explained that there is no apparent role for discography as a diagnostic tool in this particular patient. Therefore, the ____ physician consultant concluded that the requested L3-S1 discogram with CT scan following is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings/Appeals Clerk
P.O. Box 17787
Austin, TX 78744
Fax: 512-804-4011

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 9th day of September 2003.